Hy-Vee health INFUSION CARE

VYVGART (EFGARTIGIMOD ALFA-FCAB) Infusion Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: _____ **DOB:** _____ **Phone:** _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

Medical Information

Diagnosis: ☐ Myasthenia gravis w/out acute exacerbation (ICD-10 Code: G70.00)

☐ Myasthenia gravis w/acute exacerbation (ICD-10: G70.01)

☐ Other: _____ (ICD-10 Code: _____)

gMG Classification: ☐ II ☐ III ☐ IV

Patient weight: _____ lbs. (required) **Allergies:** _____

Therapy Order

Vyvgart

☐ Patients weighing <120kg (264lbs), Vyvgart 10 mg/kg IV weekly for 4 weeks

☐ Patients weighing ≥120kg (264 lbs), Vyvgart 1200 mg IV weekly for 4 weeks

Cycle may be repeated less than 50 days from start of previous cycle based on clinical evaluation. Subsequent cycles may be ordered as appropriate.

Other orders: _____

Lab Orders: _____ **Frequency:** ☐ Every infusion ☐ Other: _____

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

Anaphylactic reaction orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50 mg orally OR IV (adult)
- Refer to physician order or institutional protocol for pediatric dosing

Flush orders: NS 1-20 mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

Physician Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Provider Name: _____ **Signature:** _____ **Date:** _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

☐ Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX ☐ Phoenix, AZ ☐ Other _____

Hy-Vee health INFUSION CARE

COMPREHENSIVE SUPPORT FOR VYVGART THERAPY

Patient Information

Patient Name: _____ **DOB:** _____

Required Documentation for Referral Processing & Insurance Approval

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's current medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits or contraindications to conventional therapy

- ☐ Has the patient had a documented contraindication/intolerance or failed trial of conventional therapy (i.e., pyridostigmine, immunosuppressants, corticosteroids or acetylcholinesterase inhibitors)?
  - ☐ Yes ☐ No
  - If yes, which drug(s)? _____
- ☐ Has the patient required 2 or more courses of plasmapheresis/plasma exchanges and/or intravenous immune globulin for at least 12 months without symptom control?
  - ☐ Yes ☐ No
- ☐ Myasthenia Gravis Activities of Daily Living (MG-ADL) Score: _____
- ☐ Does patient have a history of abnormal neuromuscular transmission test demonstrated by single-fiber electromyography (SFEMG) or repetitive nerve stimulation?
  - ☐ Yes ☐ No
- ☐ Does the patient have a history of positive anticholinesterase test?
  - ☐ Yes ☐ No

☐ Include labs and/or test results to support diagnosis

- ☐ anti-AChR antibodies **(required)**

☐ If ordering a subsequent treatment cycle, and patient is new to Hy-Vee Health, please indicate the start date of the last completed cycle: _____

☐ Other medical necessity: _____

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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